

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

08841

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08852
Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmers		c. LENGTH OF STAY IN 1b 2 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.	
3. NAME OF DECEASED (Type or print) James David Campbell		d. STREET ADDRESS 1720 15th N.W.	
4. DATE OF DEATH August 18 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher		10b. KIND OF BUSINESS OR INDUSTRY D.C. School	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Josephine C. Campbell		Address 1720 15th N.W. Washington D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/1957	
22c. NAME OF CEMETERY OR CREMATORY Harmony		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE McGuire Funeral Service		24a. REC'D BY REGISTRAR 8/20/57	
24b. REGISTRAR'S SIGNATURE Aland J. Houser			

ARIZONA STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 21 1957
BUREAU V. 5

NAME: John Joseph
AGE: 2 YEARS
SEX: Male
RACE: White
DATE OF BIRTH: 1955
PLACE OF BIRTH: Phoenix, Arizona
OCCUPATION: Student
EDUCATION: High School
MARRIAGE: Never
RELIGION: Catholic
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE: [Signature]
DATE: Aug 21 1957

08842

CERTIFICATE OF DEATH

08853

Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Inigoes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Marys Hospital</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Magdelyn</u> Last <u>Carroll</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1878</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peacock</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Raley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>James W. Carroll- Dameron, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary embolism</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>Aug 31, 1957</u> , to <u>Aug 31, 1957</u> , that I last saw the deceased alive on <u>Aug 31, 1957</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Great Mills, Maryland</u> DATE SIGNED <u>9/1/57</u>							
ACTUAL SIGNATURE <u>P.J. Bean</u>		M.D. <u>Great Mills, Maryland</u> <u>9/1/57</u>					
PHYSICIAN'S NAME (Type) <u>P.J. Bean, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Marys City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Sept 1, 1957</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. 3

SEP 7 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08843

CERTIFICATE OF DEATH

Reg. Dist. No.

08854-2

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. Mary's Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Walter Last Cheseldine				4. DATE OF DEATH Month August Day 11 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 30		IF UNDER 24 HRS. Hours 30 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Cheseldine				14. MOTHER'S MAIDEN NAME Anna Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, most unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-38-3581		17. INFORMANT Mrs Elsie Cheseldine Address Avenue, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 hr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 6 a. m. 8 p. m. Month 8 Day 11 Year 1957				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Oakley,				(County) Maryland		(State) Maryland	
21. I certify that I attended the deceased from Aug 8, 1957 to Aug 11, 1957 , that I last saw the deceased alive on Aug 8, 1957 , and that death occurred at 6 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicville, Md. DATE SIGNED Leon Bexube							
ACTUAL SIGNATURE Leon Bexube M.D.							
PHYSICIAN'S NAME (Type) Leon Bexube M.D. Mechanicville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/57		22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or county) (State) Oakley, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR 8/13/57	
				24b. REGISTRAR'S SIGNATURE Glean D. Houser			

AUG 14 1957
BUREAU V

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items #3, 14, 13, & 17 - See birth cert.											
08844											
08855											
Reg. Dist. No. 255											
1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills				c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Irwin Last Edgston						4. DATE OF DEATH Month August Day 16 Year 19 57					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1957		9. AGE (In years last birthday) yrs. 22		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 22 Days 22 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Leonardtwn, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Edgston Edison						14. MOTHER'S MAIDEN NAME Marie Edgston Briscoe					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Edison Address Marie Briscoe Edgston Great Mills, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enterocolitis 7640 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 14, 1957 to Aug 16, 1957 , that I last saw the deceased alive on Aug 15, 1957 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Aug 17/57											
ACTUAL SIGNATURE P.J. Bean M.D.				GREAT MILLS, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY Holy Face		22d. LOCATION (City, town, or county) (State) Great Mills Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Mattingley						ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE Aug 17/57		24b. REGISTRAR'S SIGNATURE Local Registrar	

2078244XV5

CERTIFICATE OF DEATH

NAME OF DECEASED George Harrison		DATE OF DEATH July 22, 1957	
AGE 35		SEX Male	
RACE White		EDUCATION High School	
MARRIAGE Married		DATE OF MARRIAGE June 15, 1953	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH July 22, 1922	
OCCUPATION Salesman		PREVIOUS OCCUPATIONS None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
PLACE OF DEATH Home		DATE OF DEATH July 22, 1957	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	
SIGNATURE OF REGISTRAR None		SIGNATURE OF CLERK None	

BUREAU V. 3

AUG 30 1957

RECEIVED

08845

CERTIFICATE OF DEATH

Reg. Dist. No.

088582

1. PLACE OF DEATH o. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drayden			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hosp.				d. STREET ADDRESS Rural			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle C. Last Green				4. DATE OF DEATH Month August Day 3 Year 19 57			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1903	9. AGE (In years lost birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY State Road Comm.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Green				14. MOTHER'S MAIDEN NAME Violet C. Mason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Agnes E. Green - Drayden, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/3 , 19 57 , to 8/3 , 19 57 , that I last saw the deceased alive on 8/3/57 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Boyd M.D.				ADDRESS (Street, city or town, state) Leonardtown Md DATE SIGNED 8/5/57			
PHYSICIAN'S NAME (Type) William D. Boyd				Leonardtown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/57		22c. NAME OF CEMETERY OR CREMATORY St. Georges Cemetery		22d. LOCATION (City, town, or county) (State) Valley Lee, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Maryland				24a. RECEIVED BY REGISTRAR 8/5/57		24b. REGISTRAR'S SIGNATURE Cleland D. Hanger	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. JOHNSON		MALE		45		JAN 15 1912		CHICAGO, ILL.		LABORER	
RESIDENCE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CAUSE OF DEATH		PLACE OF DEATH	
1234 N. MAIN ST., CHICAGO, ILL.		YES		JUN 10 1935		CHICAGO, ILL.		HEART DISEASE		CHICAGO, ILL.	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
AUG 5 1957		10:30 AM		CHICAGO, ILL.		JAMES H. JOHNSON		JAMES H. JOHNSON		JAMES H. JOHNSON	
DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		BURIAL RECORD		SIGNATURE OF BURIAL		SIGNATURE OF WITNESS	
AUG 6 1957		11:00 AM		CHICAGO, ILL.		JAMES H. JOHNSON		JAMES H. JOHNSON		JAMES H. JOHNSON	

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
08846
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08857
282
CERTIFICATE OF DEATH
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b x 2 Leonardtown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Phillip Johnson		4. DATE OF DEATH Month Day Year August 17 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 / 13 / 1866
9. AGE (In years lost birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired merchant		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hilary Johnson		14. MOTHER'S MAIDEN NAME Maria Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. M.H. Johnson- Leonardtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic CV disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1950 to Aug 17 1957 , that I last saw the deceased alive on Aug 17 1957 , and that death occurred at 1057 M , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Roy Guyther		M.D. Mechanicsville, Md DATE SIGNED	
PHYSICIAN'S NAME (Type) J. Roy Guyther, M.D.		Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/20/57	22c. NAME OF CEMETERY OR CREMATORY St. Aloysius	22d. LOCATION (City, town, or county) (State) Leonardtown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson		ADDRESS - Leonardtown, Md.	
24a. REC'D BY REGISTRAR 8/20/57		24b. REGISTRAR'S SIGNATURE Alan D. Guyser	

AUG 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08847

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08858

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Texas b. COUNTY Dallas	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN lb 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Air Station		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grand Prairie 801-3	
3. NAME OF DECEASED (Type or print) First Jack Middle Earl Last LUCAS		4. DATE OF DEATH Month August Day 1 Year 1957	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1930
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min. 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Chance Vought Inc	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Coleman Lucas		14. MOTHER'S MAIDEN NAME Constance Mae McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1948-1952 463 30 0203	
17. INFORMANT (Wife) Marie Lucas		Address Lexington Park, 368 Chinlee, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries, Multiple, Extreme DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 864x (c) Immediately		INTERVAL BETWEEN ONSET AND DEATH Immediately	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Working under parked aircraft which fell on him.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Working under parked aircraft which fell on him.	
20c. TIME OF INJURY Month, Day, Year 4:28 p.m. August 1, 1957		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Air Station, Aircraft Hangar		20f. CITY OR TOWN (State) Patuxent River, St. Mary's, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Wm. D. BOYD EXAMINER'S NAME (Type) R. D. NAUMAN, CDR MC USN		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED August 1, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/57	
22c. NAME OF CEMETERY OR CREMATORY Calvary		22d. LOCATION (City, town, or county) (State) Marlin, Falls Co. Texas	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home		ADDRESS Marlin, Texas	
24a. REC'D BY REGISTRAR 8/2/57		24b. REGISTRAR'S SIGNATURE Glen D. Houser	

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		RACE		DATE OF DEATH		PLACE OF DEATH	
J. E. Smith		Male		45		White		1957		At Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		EXAMINER'S SIGNATURE	
123 Main St.		Farmer		Heart Disease		Natural		1234		J. E. Smith	
CITY		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION		U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C.	
Memphis		Shelby		Tennessee		[]		[]		[]	

RECEIVED
AUG 5 1957
BUREAU V. E.

Adams Funeral Home, Dallas, Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08859

08848

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 12 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS Loveville X2	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Morgan		4. DATE OF DEATH Month August Day 5 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1957
9. AGE (In years last birthday) yrs. 12		IF UNDER 1 YEAR Months Days Hours Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary R. Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Henry W. Morgan		Address Loveville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra cranial Bleeding 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature Birth DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 4 , 19 57 , to Aug 5 , 19 57 , that I last saw the deceased alive on Aug 5 , 19 57 , and that death occurred at 14:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 8/8/57			
ACTUAL SIGNATURE J. Roy Guyther		M.D. Mrs. Hammett	
PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.		Mechanicsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 57	
22c. NAME OF CEMETERY OR CREMATORY ST. Joseph		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR 8/8/57		24b. REGISTRAR'S SIGNATURE Dean D. Houser	

2078171 XVI

BUREAU V. S.

AUG 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08849

CERTIFICATE OF DEATH

Reg. Dist. No.

08860
282

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights X2			
				d. STREET ADDRESS 120 Fox Way			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Daisy Maria Oliver				4. DATE OF DEATH Month Day Year August 16, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1882	9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Bernard Ellis				14. MOTHER'S MAIDEN NAME Rebecca Cheseldine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph Aloysius Oliver			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive failure DUE TO (b) Arteriosclerotic CV disease DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 16, 1957 , to Aug 16, 1957 , that I last saw the deceased alive on Aug 16, 1957 , and that death occurred at 10:20 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Roy Guyther M.D.				ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 8/17/57			
PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.				Mechanicsville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) 3201 Bladensburg Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Himothy Hanlon ADDRESS 3831 Georgia Ave. N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DATE 8/20/57		24b. REGISTRAR'S SIGNATURE Dean L. Fawcett	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN BERNARD WILKINS		SEX Male		AGE 45		DATE OF BIRTH 11/15/1911	
PLACE OF BIRTH BALTIMORE, MARYLAND		RACE White		EDUCATION High School		OCCUPATION Salesman	
RESIDENCE 1200 Locust St.		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND	
DATE OF DEATH Aug 21, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		CAUSE OF DEATH Myocardial Infarction	
MANNER OF DEATH Natural		IMMEDIATE CAUSE Coronary Thrombosis		UNDERLYING CAUSE Atherosclerosis of Coronary Arteries		MORBIDITY None	
SIGNATURE OF PHYSICIAN J. Edgar Oliver		SIGNATURE OF DECEASED John Bernard Wilkins		SIGNATURE OF WITNESS John Bernard Wilkins		SIGNATURE OF WITNESS John Bernard Wilkins	
DATE OF SIGNATURE Aug 21, 1957		DATE OF SIGNATURE Aug 21, 1957		DATE OF SIGNATURE Aug 21, 1957		DATE OF SIGNATURE Aug 21, 1957	

BUREAU V. B.

AUG 21 1957

RECEIVED

08850

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Thomas Middle M. Last Smith				4. DATE OF DEATH Month August Day 7 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1888	
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months 26 Days 26 Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Boys School	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Louis Jefferson Smith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Lue Dailey Address Leonardtwn, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronitis of Lores. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 2nd , 19 57 , to Aug 7th , 19 57 , that I last saw the deceased alive on August 7th , 19 57 , and that death occurred at 5 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Greenwell M.D.				ADDRESS (Street, city or town, state) Leonardtwn Maryland			
DATE SIGNED				DATE SIGNED			
PHYSICIAN'S NAME (Type) Charles Greenwell M.D.				ADDRESS Leonardtwn, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/57		22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Valley Lee, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE 8/9/57	
24b. REGISTRAR'S SIGNATURE Glenn D. Hauser							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED
AUG 12 1957
BUREAU V. T.

AUG 12 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 08851
 CERTIFICATE OF DEATH

Reg. Dist. No.

08862
 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Ernest Last Somerville				4. DATE OF DEATH Month August Day 15 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1946	
9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR Months 2 Days 19 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mitchell Somerville				14. MOTHER'S MAIDEN NAME Agnes Stevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mitchell Somerville Address Hollywood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enteritis 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Toxemia due to enteritis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 27, 1956 to August 15, 1957 , that I last saw the deceased alive on August 15, 1957 , and that death occurred at 3: P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Greenwell M.D.				ADDRESS (Street, city or town, state) Leonardtwn Maryland			
SIGNATURE'S NAME (Type) Charles Greenwell M.D.				LOCATION (City, town, or county) (State) Leonardtwn, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 8/16/57		24b. REGISTRAR'S SIGNATURE Alvin D. Lousier	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

AUG 19 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08863

08852

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Hollywood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Marys Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wellington</u> Last <u>Wathen, Sr.</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH <u>9/30/1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John H. Wathen</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Joy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. -----			
17. INFORMANT <u>John W. Wathen, Jr.</u>				Address <u>Lexington Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetic</u> DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>57</u> , to <u>August 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 6</u> , 19 <u>57</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Charles Greenwell</u> M.D. <u>Leonardtwn, Md.</u> PHYSICIAN'S NAME (Type) <u>Charles Greenwell, M.D.</u> <u>Leonardtwn, Md.</u> <u>8/8/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtwn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>William R. Hauer</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth	
5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death	
9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of coroner		19. Signature of medical examiner		20. Signature of pathologist	
21. Signature of anatomist		22. Signature of histologist		23. Signature of bacteriologist		24. Signature of virologist	
25. Signature of epidemiologist		26. Signature of public health nurse		27. Signature of health visitor		28. Signature of social worker	
29. Signature of psychologist		30. Signature of psychiatrist		31. Signature of sociologist		32. Signature of anthropologist	
33. Signature of linguist		34. Signature of geographer		35. Signature of meteorologist		36. Signature of climatologist	
37. Signature of oceanographer		38. Signature of astronomer		39. Signature of physicist		40. Signature of chemist	
41. Signature of biologist		42. Signature of geologist		43. Signature of environmental scientist		44. Signature of conservationist	
45. Signature of naturalist		46. Signature of ecologist		47. Signature of botanist		48. Signature of zoologist	
49. Signature of entomologist		50. Signature of ornithologist		51. Signature of herpetologist		52. Signature of ichthyologist	
53. Signature of mammalogist		54. Signature of paleontologist		55. Signature of archaeologist		56. Signature of anthropologist	
57. Signature of linguist		58. Signature of geographer		59. Signature of meteorologist		60. Signature of climatologist	
61. Signature of oceanographer		62. Signature of astronomer		63. Signature of physicist		64. Signature of chemist	
65. Signature of biologist		66. Signature of geologist		67. Signature of environmental scientist		68. Signature of conservationist	
69. Signature of naturalist		70. Signature of ecologist		71. Signature of botanist		72. Signature of zoologist	
73. Signature of entomologist		74. Signature of ornithologist		75. Signature of herpetologist		76. Signature of ichthyologist	
77. Signature of mammalogist		78. Signature of paleontologist		79. Signature of archaeologist		80. Signature of anthropologist	
81. Signature of linguist		82. Signature of geographer		83. Signature of meteorologist		84. Signature of climatologist	
85. Signature of oceanographer		86. Signature of astronomer		87. Signature of physicist		88. Signature of chemist	
89. Signature of biologist		90. Signature of geologist		91. Signature of environmental scientist		92. Signature of conservationist	
93. Signature of naturalist		94. Signature of ecologist		95. Signature of botanist		96. Signature of zoologist	
97. Signature of entomologist		98. Signature of ornithologist		99. Signature of herpetologist		100. Signature of ichthyologist	
101. Signature of mammalogist		102. Signature of paleontologist		103. Signature of archaeologist		104. Signature of anthropologist	
105. Signature of linguist		106. Signature of geographer		107. Signature of meteorologist		108. Signature of climatologist	
109. Signature of oceanographer		110. Signature of astronomer		111. Signature of physicist		112. Signature of chemist	
113. Signature of biologist		114. Signature of geologist		115. Signature of environmental scientist		116. Signature of conservationist	
117. Signature of naturalist		118. Signature of ecologist		119. Signature of botanist		120. Signature of zoologist	
121. Signature of entomologist		122. Signature of ornithologist		123. Signature of herpetologist		124. Signature of ichthyologist	
125. Signature of mammalogist		126. Signature of paleontologist		127. Signature of archaeologist		128. Signature of anthropologist	
129. Signature of linguist		130. Signature of geographer		131. Signature of meteorologist		132. Signature of climatologist	
133. Signature of oceanographer		134. Signature of astronomer		135. Signature of physicist		136. Signature of chemist	
137. Signature of biologist		138. Signature of geologist		139. Signature of environmental scientist		140. Signature of conservationist	
141. Signature of naturalist		142. Signature of ecologist		143. Signature of botanist		144. Signature of zoologist	
145. Signature of entomologist		146. Signature of ornithologist		147. Signature of herpetologist		148. Signature of ichthyologist	
149. Signature of mammalogist		150. Signature of paleontologist		151. Signature of archaeologist		152. Signature of anthropologist	
153. Signature of linguist		154. Signature of geographer		155. Signature of meteorologist		156. Signature of climatologist	
157. Signature of oceanographer		158. Signature of astronomer		159. Signature of physicist		160. Signature of chemist	
161. Signature of biologist		162. Signature of geologist		163. Signature of environmental scientist		164. Signature of conservationist	
165. Signature of naturalist		166. Signature of ecologist		167. Signature of botanist		168. Signature of zoologist	
169. Signature of entomologist		170. Signature of ornithologist		171. Signature of herpetologist		172. Signature of ichthyologist	
173. Signature of mammalogist		174. Signature of paleontologist		175. Signature of archaeologist		176. Signature of anthropologist	
177. Signature of linguist		178. Signature of geographer		179. Signature of meteorologist		180. Signature of climatologist	
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189. Signature of naturalist		190. Signature of ecologist		191. Signature of botanist		192. Signature of zoologist	
193. Signature of entomologist		194. Signature of ornithologist		195. Signature of herpetologist		196. Signature of ichthyologist	
197. Signature of mammalogist		198. Signature of paleontologist		199. Signature of archaeologist		200. Signature of anthropologist	

RECEIVED
AUG 12 1957
BUREAU V. E.